**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

TX HEALTH FORT WORTH
3255 W PIONEER PKWY
ARLINGTON TX 76013

**Respondent Name**
Wal Mart Associates Inc

**Carrier's Austin Representative Box**
Box Number 53

**MFDR Tracking Number**
M4-13-0489-01

**MFDR Date Received**
October 17, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule…"

**Amount in Dispute:** $6,304.05

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Carrier has evaluated & replied to appeals x 3, with extensive & detailed responses mailed to provider."

**Response Submitted by:** Hoffman Kelley, 5316 Hwy 290 West, Suite360, Austin, TX 78735

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 5, 2012 | Outpatient Hospital Services | $6,304.05 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated May 6, 2012

- 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE

PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE
- 243 – THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED
- 285 – PLEASE REFER TO THE NOTE ABOVE FOR A DETAILED EXPLANATION OF THE REDUCTION
- 799 – ALLOWANCE HAS BEEN ADJUSTED IN ACCORDANCE WITH OPPS SCHEDULE ALLOWANCE
- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
- 899 – IN ACCORDANCE WITH CLINICAL BASED CODING EDITS (NATIONAL CORRECT CODING SYSTEM PROCEDURE (2000-29999) HAS BEEN DISALLOWED.
- 954 – THE ALLOWANCE FOR NORMALLY PACKAGED REVENUE AND/OR SERVICE CODES HAVE BEEN PAID IN ACCORDANCE WITH THE DISPERSED OUTPATIENT ALLOWANCE
- 5036 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM –UR/JE

Explanation of benefits dated October 15, 2012
- 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
- 285 – PLEASE REFER TO THE NOTE ABOVE FOR A DETAILED EXPLANATION OF THE REDUCTION
- 799 – ALLOWANCE HAS BEEN ADJUSTED IN ACCORDANCE WITH OPPS SCHEDULE ALLOWANCE
- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
- 899 – IN ACCORDANCE WITH CLINICAL BASED CODING EDITS (NATIONAL CORRECT CODING SYSTEM PROCEDURE (2000-29999) HAS BEEN DISALLOWED.
- 1014 – THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THE RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.
- 5036 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM –UR/JE

Explanation of benefits dated November 2, 2012
- 85 – INTEREST PAYMENT
- 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
- 285 – PLEASE REFER TO THE NOTE ABOVE FOR A DETAILED EXPLANATION OF THE REDUCTION
- 799 – ALLOWANCE HAS BEEN ADJUSTED IN ACCORDANCE WITH OPPS SCHEDULE ALLOWANCE
- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE
- 899 – IN ACCORDANCE WITH CLINICAL BASED CODING EDITS (NATIONAL CORRECT CODING SYSTEM PROCEDURE (2000-29999) HAS BEEN DISALLOWED.
- 954 – THE ALLOWANCE FOR NORMALLY PACKAGED REVENUE AND/OR SERVICE CODES HAVE BEEN PAID IN ACCORDANCE WITH THE DISPERSED OUTPATIENT ALLOWANCE.
- 1001 – BASED ON THE CORRECTED BILLING AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER, WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FOR THE ABOVE NOTED PROCEDURE CODE.
- 5036 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM –UR/JE

**Issues**

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

**Findings**

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code L3670 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $99.50. 125% of this amount is $124.38
   - Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 29827 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $3,991.87. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,395.12. This amount multiplied by the annual wage index for this facility of 0.9506 yields an adjusted labor-related amount of $2,276.80. The non-labor related portion is 40% of the APC rate or $1,596.75. The sum of the labor and non-labor related amounts is $3,873.55. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $3,873.55 divided by the sum of all S and T APC payments of $4,881.00 gives an APC payment ratio for this line of 0.793598, multiplied by the sum of all S and T line charges of $7,775.50, yields a new charge amount of $6,170.62 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,900, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.222. This ratio multiplied by the billed charge of $6,170.62 yields a cost of $1,369.88. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $3,873.55 divided by the sum of all APC payments is 79.18%. The sum of all packaged costs is $2,265.76. The allocated portion of packaged costs is $1,794.06. This amount added to the service cost yields a total cost of $3,163.94. The

cost of these services exceeds the annual fixed-dollar threshold of $1,900. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $3,873.55. This amount multiplied by 200% yields a MAR of $7,747.10.

- Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $2,076.45. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,245.87. This amount multiplied by the annual wage index for this facility of 0.9506 yields an adjusted labor-related amount of $1,184.32. The non-labor related portion is 40% of the APC rate or $830.58. The sum of the labor and non-labor related amounts is $2,014.90. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $1,007.45 divided by the sum of all S and T APC payments of $4,881.00 gives an APC payment ratio for this line of 0.206402, multiplied by the sum of all S and T line charges of $7,775.50, yields a new charge amount of $1,604.88 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $1,007.45. This amount multiplied by 200% yields a MAR of $2,014.90.
- Per Medicare policy, procedure code 29824 may not be reported with procedure code 29827 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Per Medicare policy, these two codes may not be reported on the same date of service unless an appropriate modifier is appended to the component code to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service without a modifier. Separate payment is not recommended.
- Per Medicare policy, procedure code 29822 may not be reported with the procedure code 29827 billed on this same claim. Payment for this service is included in the payment for the primary procedure. Per Medicare policy, these two codes may not be reported on the same date of service unless an appropriate modifier is appended to the component code to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with a modifier; however, review of the submitted medical documentation finds that modifier 59 is not supported. Separate payment is not recommended.
- Per Medicare policy, procedure code 64415 may not be reported with procedure code 29822 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Per Medicare policy, these two codes may not be reported on the same date of service unless an appropriate modifier is appended to the component code to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with a modifier; however, review of the submitted medical documentation finds that modifier 59 is not supported. Separate payment is not recommended.
- Procedure code J0131 has a status indicator of G, which denotes pass-through drugs and biologicals paid under OPPS; separate APC payment includes pass-through amount. These services are classified under APC 9283, which, per OPPS Addendum A, has a payment rate of $0.11. This amount multiplied by 60% yields an unadjusted labor-related amount of $0.07. This amount multiplied by the annual wage index for this facility of 0.9506 yields an adjusted labor-related amount of $0.07. The non-labor related portion is 40% of the APC rate or $0.04. The sum of the labor and non-labor related amounts is $0.11 multiplied by 100 units is $11.00. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total Medicare facility specific reimbursement amount for this line is $11.00. This amount multiplied by 200% yields a MAR of $22.00.
- Procedure code J0171 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1790 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code J2795 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code Q0162 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

3. The total allowable reimbursement for the services in dispute is $9,908.38. This amount less the amount previously paid by the insurance carrier of $12,177.65 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | July 22, 2013<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.